



DIA USE ONLY

**EMPLOYER'S FIRST REPORT OF INJURY
 OR FATALITY**

THIS FORM MUST BE FILED BY THE **EMPLOYER** IN THE EVENT OF AN INJURY THAT RESULTS IN DEATH OR FIVE OR MORE CALENDAR DAYS OF TOTAL OR PARTIAL INCAPACITY FROM EARNING WAGES.
 INSTRUCTIONS AND CODES ON THE REVERSE SIDE - Please Print Legibly or Type - Unreadable forms will be returned.

EMPLOYEE	1. Employee's Name (Last, First, MI):		2. Home Telephone Number:	3. Social Security Number*:	4. Sex: <input type="checkbox"/> M <input type="checkbox"/> F
	5. Home Address (No., Street, City, State & Zip Code):			6. Marital Status: <input type="checkbox"/> M <input type="checkbox"/> S	7. No. of Dependents:
	8. Date of Hire (mm/dd/yyyy):	9. Date of Birth (mm/dd/yyyy):		10. Average Weekly Wage: s <input type="checkbox"/> Estimated <input type="checkbox"/> Actual	
EMPLOYER	11. Employer's Name:			12. Federal Tax I.D. Number:	
	13. Employer's Address (No., Street, City, State & Zip Code):			14. Employer's Telephone Number:	
	16. Workers' Compensation Insurance Carrier and Tel. No. (NOT LOCAL AGENT/ADMINISTRATOR): Meadowbrook TPA Associates			15. Industry Code (See Reverse Side):	
	18. Self-Insured? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 10 New England Business Ctr. If Yes, Self-Insurer Number: (817) Suite 303 Andover, MA 01810			17. W.C. Policy Number:	
INJURY INFORMATION	20. DATE OF INJURY (mm/dd/yyyy):				
	21. Was Employee Injured on Employer's Premises? <input type="checkbox"/> Yes <input type="checkbox"/> No		22. Location of Injury if not on Employer's Premises:		
	23. FIRST day of Total or Partial Incapacity to Earn Wages (mm/dd/yyyy):		24. FIFTH day of Total or Partial Incapacity to Earn Wages (mm/dd/yyyy):		
	25. If Employee has Died, Date of Death (mm/dd/yyyy):		26. Source of Injury (Chemicals, Machinery, etc.):		
	27. Briefly Describe How Injury/Exposure Occurred and Body Part(s) involved:				
	28. Person to Whom Injury was Reported (list position):		29. Date Reported (mm/dd/yyyy):	30. Date Reported as work related (mm/dd/yyyy):	
	31. Injury Code(s) to body part		32. Witness(es) to Injury - Give Full Name(s), if none state as such:		
33. Has Employee Returned to Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		34. Date Employee Returned to Work(mm/dd/yyyy):			
35. Employee's Regular Occupation:		36. Has Employee Returned to Regular Occupation: <input type="checkbox"/> Yes <input type="checkbox"/> No			
37. EMPLOYER'S Name (SEE INSTRUCTIONS ON REVERSE SIDE):			38. Title:		
39. EMPLOYER'S Signature (SEE INSTRUCTIONS ON REVERSE SIDE):			40. Date Prepared (mm/dd/yyyy):		

*Disclosure of Social Security Number is Voluntary. It will aid in the processing of your report. Form 101 - Revised 8/2001 - Reproduce as needed.
THIS FORM DOES NOT CONSTITUTE AN EMPLOYEE'S CLAIM FOR BENEFITS UNDER WORKERS' COMPENSATION.